IN THE UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF VIRGINIA
Newport News Division

GAVIN GRIMM,

Plaintiff,

v. Case No. 4:15-cv-54

GLOUCESTER COUNTY SCHOOL BOARD,

Defendant.

GLOUCESTER COUNTY SCHOOL BOARD'S RULE 26(a)(2) DISCLOSURE

NOW COMES the Defendant Gloucester County School Board ("School Board"), by counsel, and hereby discloses the following expert in accordance with Rule 26(a)(2) of the Federal Rules of Civil Procedure.

The School Board submits this disclosure without conceding that expert testimony is appropriate or needed with regard to the claims against the School Board, and without prejudice to or waiving the School Board's right to summary judgment and/or a judgment as a matter of law at the conclusion of plaintiff's evidence.

The following information is offered only as a summary of the respective expert's opinions and the grounds underlying those opinions. The School Board reserves the right to supplement, modify and/or change this expert disclosure as the expert continues to review this matter on behalf of the School Board and as additional discovery is conducted. The expert opinion is based on the expert's training, education and experience, as well as his review of the documents and other relevant materials noted in the reports. All opinions expressed will be offered to a reasonable degree of certainty in the witness' field of expertise unless stated

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otherwise. The expert witness may render additional opinions or expound on the opinions listed in the reports at his depositions. The report and opinion testimony of the expert is incorporated in this Disclosure by reference.

Quentin L. Van Meter, M.D.
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The School Board reserves the right to call as a witness, Dr. Quentin L. Van Meter, an expert in the field of pediatric endocrinology. Dr. Van Meter's expert report and CV are attached to this Disclosure and incorporated by reference as if fully set forth herein. (Exhibit 1).

GLOUCESTER COUNTY SCHOOL BOARD

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I hereby certify that a true copy of the foregoing was emailed and mailed this 26th day of February, 2019 to:

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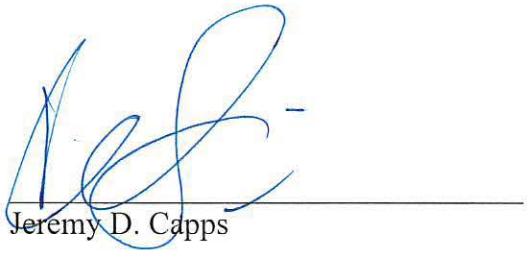

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26 February, 2019

1. I have been retained by counsel for the Gloucester County School Board as an expert in connection with the above-captioned litigation. I have actual knowledge of the matters stated in this report. My professional background, experience, and publications are detailed in my curriculum vitae, which is attached as Exhibit A.

2. I received my B.A. in Science at the College of William and Mary, and my M.D. from the Medical College of Virginia, Virginia Commonwealth University.

3. I am currently a pediatric endocrinologist in private practice in Atlanta Georgia. I am the President of Van Meter Pediatric Endocrinology, P.C. I am on the clinical faculties of Emory University School of Medicine and Morehouse College of Medicine, in the role of adjunct Associate Professor of Pediatrics.

4. I am board certified in Pediatrics and Pediatric Endocrinology. I have been licensed to practice medicine in Georgia since 1991. I have been previously licensed to practice medicine in California, Louisiana, and Maryland.

5. I did my Pediatric Endocrine fellowship at Johns Hopkins Hospital from 1978-1980. The faculty present at that time had carried on the tradition of excellence established by Lawson Wilkins, M.D. Because of the reputation of the endocrine program as a center for exceptional care for children with disorders of sexual differentiation, I had well-above average exposure to such patients. As a Pediatric Fellow, I was also exposed to adults with Gender Identity Disorder, then called Trans-Sexuality, and received training from John Money, Ph.D., in his Psychohormonal Division.

6. I have maintained a continued interest in gender discordance since my fellowship years and have read extensively the literature in scientific peer-reviewed journals and have attended national and international pediatric endocrine conferences where this subject is presented and discussed. I am also familiar with the wide array of commentary on the subject.

7. My professional memberships include The Pediatric Endocrine Society, the Endocrine Society, the American Association of Clinical Endocrinologists where I held a position on the Pediatric Scientific Committee until it was disbanded one year ago, the American Diabetes Association, and I am a fellow of the American College of Pediatricians, currently serving on the Board of Directors as President. I am on the Advisory Board of Camp Kudzu, a non-profit organization which provides diabetes camp experience in Georgia.

8. My opinions expressed in this report are based upon my education, training, and experience in the subject matters discussed. The materials that I have relied upon are the same types of materials that

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other experts in my field rely upon when forming opinions. Specific sources upon which I rely in this report are footnoted.

9. Over my career, I have served as an expert witness in medical malpractice cases for both plaintiff and defense. I have testified at Georgia State Legislative Committee hearings. In the past six years, I have testified by deposition in Harlen Schneider v. J. Enrique Lujan, M.D.et al., in the circuit court of the first judicial circuit of Okaloosa County, FL, Civil Division, on 7 Feb 2014; and in the case of plaintiff Kimora Gilmer, represented by attorneys at the Birmingham, AL, firm of Pittman Dutton on 22 May 2014.

10. I provided an expert declaration in the case of Carcano v McCorey and US vs North Carolina on 12 August 2016. I testified in Springfield. Illinois as a plaintiff's expert witness in the case of Cooley v. Paul for the firm of Kanoski Bresney, 3 Nov 2017. I testified in court in Hamilton County Ohio in February 2018 in regard to Jessica Siefert, a transgender teen who had been removed from the custody of her biologic parents. I testified via skype in Alberta Province, Canada on 14 June 2018 in regard to the matter of parents suing the school systems there for withholding information about transgender-promoting programs in the public schools from the parents. My publications include a textbook chapter, case studies, and articles generated by clinical research studies. I serve on the speaker's bureau of major pharmaceutical companies.

11. I am being compensated at an hourly rate for actual time devoted, at the rate of $350 per hour. My compensation does not depend on the outcome of this litigation, the opinions I express, or the testimony I provide.

Sexual Differentiation in the Fetus

12. From the moment of conception, a fetus is determined to be either a male (XY), female (XX), or in rare cases, to have a combination of sex-determining chromosomes, many of which are not compatible with life, and some of which are the cause of identifiable clinical syndromes. The presence of a Y chromosome in the developing fetus directs the developing gonadal tissue to develop as a testicle. The absence of a functional Y chromosome allows the gonadal tissue to develop as an ovary. Under the influence of the mother's placental hormones, the testicle will produce testosterone which directs the genital tissue to form a penis and a scrotum. Simultaneously, the testicle produces anti-Müllerian Hormone (AMH) which regresses development of the tissue that would otherwise develop into the uterus, fallopian tubes, and upper third of the vagina.

13. This combination of actions in early fetal development is responsible for what we subsequently see on fetal sonograms, and what we observe at birth as male or female genitalia. It is only when the genital structures are ambiguous in appearance that sex assignment is withheld until a thorough expert team evaluation has occurred.

14. For reasons most often occurring as random events, there are malfunctions of the normal differentiation. These aberrations of normal development are responsible for what we classify as Disorders of Sexual Differentiation (DSD) and they represent a very small fraction of the human population. The incidence of such circumstances occurs in 1:4500 to 1:5500 births[1]

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1 Lee PA et al, Global Disorders of Sex Development Update since 2006: Perceptions, Approach and Care, 2016 Horm Res Paediatr

15. Sex is binary, male or female, and is determined by chromosomal complement and corresponding reproductive role. The exceedingly rare DSDs are all medically identifiable deviations from the human binary sexual norm. The 2006 consensus statement of the Intersex Society of North America and the 2015 revision of the Statement does not endorse DSD as a third sex.[2]

16. DSD outcomes range from appearance of female external genitalia in an XY male (complete androgen insensitivity syndrome) to appearance of male external genitalia in an XX female (severe congenital adrenal hyperplasia). As one would expect, there are variations of the degree of hormonally driven changes that create ambiguous genital development that prevent assigning of a specific classification as either male or female at birth.

17. DSD patients are not "transgender"; they have an objective, physical, medically verifiable, physiologic condition. Transgender people generally do not have intersex conditions or any other verifiable physical anomaly. People who identify as "feeling like the opposite sex" or "somewhere in between" do not comprise a third sex. They remain biological men or biological women.

18. "Gender" is a term that refers to the psychological and cultural characteristics associated with biological sex. It is a psychological concept and sociological term, not a biological one. The term gender possessed solely a linguistic meaning prior to the 1950s. This changed when sexologists of the 1950s and 1960s manipulated the term to conceptualize cross-dressing and transsexualism in their psychological practice.

19. "Gender identity" is a term coined by my former endocrine faculty member John Money in the 1970s and has come to refer to an individual's mental and emotional sense of being male or female. The norm is for individuals to have a gender identity that aligns with one's biological sex.

20. Gender discordance (formerly Gender Identity Disorder) is used to describe a psychological condition in which a person experiences marked incongruence between his experienced gender and the gender associated with his biological sex. He will often express the belief that he is the opposite sex.

21 Gender discordance occurs in 0.001% of biological females and in 0.0033% of biological males.[3] Exact numbers are hard to document since reporting is often anecdotal. Gender discordance is not considered a normal developmental variation.

22. "Gender Dysphoria" is a diagnostic term to describe the emotional distress caused by gender incongruity.[4]

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2 Lee PA et al, Consensus Statement on Management of Intersex Disorders, Pediatrics 2006; 118 e488-e500.

3 Seaborg E, About Face, Endocrine News 2014 (May) 16-19.

4 American Psychiatric Association. Diagnostic and Statistical Manual of Mental Disorders. 5th ed; 2013:451-459.

Etiology of Gender Disorders

23. Transgender affirming professionals claim transgender individuals have a "feminized brain" trapped in a male body at birth and vice versa based upon various brain studies. Diffusion-weighted MRI scans have demonstrated that the pubertal testosterone surge in boys increases white matter volume. A study by Rametti and colleagues found that the white matter microstructure of the brains of female-to-male (FtM) transsexual adults, who had not begun testosterone treatment, more closely resembled that of men than that of women.[5] Other diffusion-weighted MRI studies have concluded that the white matter microstructure in both FtM and male-to-female (MtF) transsexuals falls halfway between that of genetic females and males.[6] These studies, however, are of limited clinical significance due to the small number of subjects and failure to account for neuroplasticity.

24. Neuroplasticity is the well-established phenomenon in which long-term behavior alters brain microstructure. For example, the MRI scans of experienced cab drivers in London are distinctly different from those of non-cab drivers, and the changes noted are dependent on the years of experience.[7] There is no evidence that people are born with brain microstructures that are forever unalterable, but there is significant evidence that experience changes brain microstructure.[8,9] Therefore, any transgender brain differences would more likely be the result of transgender behavior than its cause.

25. Furthermore, infants' brains are imprinted prenatally by their own endogenous sex hormones, which are secreted from their gonads beginning at approximately eight weeks' gestation.[10,11,12] There are no published studies documenting MRI-verified differences in the brains of gender-disordered children or adolescents. The DSD guidelines also specifically state that current MRI technology cannot be used to identify those patients who should be raised as males or raised as females.[13]

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5 Rametti G, Carrillo B, Gomez-Gil E, et al. White matter microstructure in female to male transsexuals before cross-sex hormonal treatment. A diffusion tensor imaging study. J Psychiatr Res 2011;45:199-204.

6 Kranz GS, Hahn A, Kaufmann U, et al. White matter microstructure in transsexuals and controls investigated b diffusion tensor imaging. J Neurosci 2014;34(46):15466-15475.

7 Maguire EA et al, Navigation-related structural change in the hippocampi of taxi drivers, PNAS 2000;97:4398- 4403.

8 Gu J, Kanai R. What contributes to individual differences in brain structure? Front Hum Neurosci 2014;8:262.

9 Sale A, Berardi N, Maffei L, Environment and Brain Plasticity: Towards an Endogenous Pharmacotherapy, Physiol Rev 2014; 94: 189 –234.

10 Reyes FI, Winter JS, Faiman C. Studies on human sexual development fetal gonadal and adrena sex steroids. J Clin Endocrinol Metab 1973; 37(1):74-78.

11 Lombardo M. Fetal testosterone influences sexually dimorphic gray matter in the human brain. J Neurosci 2012; 32:674-680.

12 Campano A. [ed]. Geneva Foundation for Medical Education and Research. Human Sexual Differentiation;2016Availableat:www.gfmer.ch/Books/Reproductive_health/Human_sexual_differentiation.html. Accessed May 11, 2016.

13 Lee PA et al, Consensus Statement on Management of Intersex Disorders, Pediatrics 2006; 118 e488-e500.

26. Behavior geneticists have known for decades that while genes and hormones influence behavior, they do not hard-wire a person to think, feel, or behave in a particular way. The science of epigenetics has established that genes are not analogous to rigid "blueprints" for behavior. Rather, humans "develop traits through the dynamic process of gene-environment interaction. ... [genes alone] don't determine who we are." [14]

27. Regarding transgenderism, twin studies of adults prove definitively that prenatal genetic and hormone influence is minimal. The largest twin study of transgender adults found that only 10 percent of identical twins were both transgender-identified.[15] Since identical twins contain 100 percent of the same DNA from conception and develop in exactly the same prenatal environment exposed to the same prenatal hormones, if genes and/or prenatal hormones contributed to a significant degree to transgenderism, the concordance rates would be close to 100 percent. Instead, 80 percent of identical twin pairs were discordant. This would indicate that at least 80 percent of what contributes to transgenderism as an adult in one co-twin consists of one or more non-shared post-natal experiences including but not limited to non-shared family experiences.

28. These findings also mean that persistent GD is due predominately to the impact of nonshared environmental influences. These studies provide compelling evidence that discordant gender is not hard-wired genetically.

Gender Dysphoria vs. Gender Identity Disorder

29. Up until the recent revision of the DSM-IV criteria, the American Psychological Association (APA) held that Gender Identity Disorder (GID) was the mental disorder described as a discordance between the natal sex and the gender identity of the patient.

30. Dr. Kenneth Zucker, who is a highly respected clinician and researcher from Toronto carried on evaluation and treatment of GID patients for forty years. His works, widely published, found that the vast majority of boys and girls with GID identify with their biological sex by the time they emerge from puberty to adulthood, through either watchful waiting or family and individual counseling.[17] His results were mirrored in studies from Europe.[18,19] When the DSM-V revision of the diagnosis of GID was proposed by the APA committee responsible for revision, Dr. Zucker insisted that there be a medical term to replace Gender Identity Disorder, removing gender discordance as a mental disorder apart from the presence of significant emotional distress. With this revision, Gender Dysphoria describes the mental anguish which is experienced by the gender discordant patient.

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14 Shenk, D. The Genius in All of Us: Why everything you've been told about genetics, talent, and IQ is wrong. (2010) New York, NY: Doubleday; p. 18.

15 Diamond, M. "Transsexuality Among Twins: identity concordance, transition, rearing, and orientation." International Journal of Transgenderism, 14(1), 24–38.

17 Zucker KJ, Gender Identity Disorder, in Rutter M, Taylor EA, editors. Child and Adolescent psychiatry, 4th ed, Malden Mass: Blackwell, 2006: 737-753.

18 Wallien MS, Cohen-Kettenis PT. Psychosexual outcome of gender-dysphoric children. J AM Academy Child Adolescent Psychiatry 2008; 47:1413-1423.

19 Schechner T. Gender Identity Disorder: A Literature Review from a Developmental Perspective. *Isr J PsychiatryRelated Sci* 2010; 47:42-48.

31. The theory that societal rejection is the root cause of Gender dysphoria was validly questioned by a study from Sweden which showed that the dysphoria was not eliminated by hormones and sex reassignment surgery even with widespread societal acceptance.[20]

Treatment of Gender Dysphoria

32. The treatment of the child and adolescent with gender discordance and accompanying gender dysphoria should include an in-depth evaluation of the child and family dynamics. This provides a basis on which to proceed with psychologic therapy. The entire biologic and social family should be involved in psychological therapy designed to assist the patient, if at all possible, to align gender identity with natal sex. Psychological support by competent counselors with an intent of resolving the gender conflict should be provided as long as the patient continues to suffer emotionally. Given the high degree of eventual desistance of gender discordance/dysphoria by the end of puberty, it would be ethical and logical to counsel the patient and family to rear the child in conformity with natal sex.

33. Erikson described the stage of adolescence as "Identity versus Role Confusion" during which the teen works at developing a sense of self by testing roles then integrating them into a single identity.[21] This process is often unpleasant regardless of the presence or absence of gender identity conflicts. The major benefit of enduring puberty in a GD patient is that it provides a strong likelihood of alignment of his gender identity with his natal sex. There is no doubt that these patients need compassionate care to get them through their innate pubertal changes. Scientific evidence shows that 80%-95% of pre-pubertal children with GD will come to identify with their biological sex by late adolescence. Some will require lifelong supportive counseling, and others will not.[22]

Science vs. Pseudoscience

34. The advent of "centers of excellence" for gender-disordered patients[23] combined with sociologic agenda in academia has created the impression that there is scientific validity to gender discordance as a variation of normal. There has been a flurry of non-peer-reviewed articles in journals and newsletters circulated to general pediatricians that promote the ideology of transgenderism without scientific support.[24,25,26,27] Mainstream clinicians and scientists who consider gender discordance to be a mental disorder have been deliberately excluded in the makeup of the steering committees of academic and medical professional societies which are promulgating guidelines that were previously unheard of.

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20 Dhejne, Cecilia et al. Long-term Follow- up of transsexual Persons Undergoing Sex Reassignment Surgery:Cohort Study in Sweden *PLoS One* February 2011 Vol 6 Issue 2, e16885

21 Erikson, E. H. (1993). *Childhood and society*. WW Norton & Company. Erikson, E. H. (1993). *Childhood and society*. WW Norton & Company.

22 Zucker KJ, Gender Identity Disorder, in Rutter M, Taylor EA, editors. *Child and Adolescent psychiatry*, 4th ed, Malden Mass: Blackwell, 2006: 737-753.

23 Hsieh S and Leninger J, Resource List: Clinical Care Programs for Gender-Nonconforming Children and Adolescents, *Pediatr Ann* 2014:43:238-244.

24 Prager, LM, A boy who wants to be a girl, *Contemporary Pediatrics 2008*; 25:56-58.

25 Garafolo R Tipping points in caring for the gender-non-conforming child and adolescent, *Pediatr Ann* 2014;43:227-229.

26 Steever J, Cross-gender Hormone therapy in adolescents, *Pediatr Ann* 2014;43: e-138-e-144.

27 Simons LK et al, Understanding gender variance in Children and Adolescents, *Pediatr Ann*2014;43:e-126-e131.

35. The Endocrine Society published such a document in 2009.[28] Its recommendations promoted the use of psychological evaluation, counseling, blocking of pubertal maturation at the onset of puberty, the subsequent use of cross- sex hormones, and possible surgical intervention at the age of consent. Of the 22 recommendations contained in the document, only three were supported by scientific proof. These three warned of potential adverse effects of hormonal manipulation. The remaining 19 recommendations were nearly evenly split into a group that was based on very limited scientific evidence and a group that was based on no scientific evidence at all. The response to these guidelines was a burgeoning of Gender Identity Clinics in the United States from three to over forty-five in a period of seven years. Subsequently, the Endocrine Society revised the guidelines and the modifications were more permissive with the younger ages at which cross-sex hormones and surgical treatment could be recommended. They did add a concern that counseling regarding induced infertility should be included.[29]

The Pediatric Endocrine Society created their own guidelines[30] as did the American Academy of Pediatrics.[31] Each of these subsequent guidelines were more lenient and the AAP actually suggested that initial evaluation for undercurrent psychological issues be abandoned altogether.

36. WPATH is an agenda-driven advocacy organization whose membership consists of anyone who has an interest in the transgender social and political agenda. There are no requirements for specialty training or certification. Its guidelines and standards of care are not scientifically supported.

37. WPATH promotes "expert witnesses" and provides them with a bibliography replete with self-confirming references to opinion pieces and anecdotal case reports along with clinical case reviews with inherent selection bias.

38. WPATH's "peer-reviewed" journal is not reviewed by anyone with an opinion that is not in keeping with the philosophy of the organization itself.

39. I reviewed the legal complaint filed on behalf of the plaintiff, Gavin Grimm as well as the deposition of Gavin Grimm and the declaration by expert witness, Dr. Melinda Penn. I direct my strongest criticism at the information that was presented to support the affirmation of the gender incongruence through counseling, medical and surgical intervention. Statements were made that such action is clearly the only scientifically valid way to proceed, when the breadth of medical literature does not support this concept.

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28 Hembree WC et al, Endocrine Treatment of Transsexual Persons: and Endocrine Society Clinical PracticeGuideline, *J Clin Endo Metab*2009; 94:3132-3154.

29. Hembree WC et al, Endocrine Treatment of Gender-Dysphoric/Gender-Incongruent Persons: an Endocrine Society Clinical Practice Guideline, J Clin Endo Metab 2017 ;102:3869-3903.

30. https//www.pedsendo.org.../TG_SIG_%20Statement_10_220_16.pdf

31. Rafferty J, Ensuring Comprehensive Care and Support for Transgender and Gender-Diverse Children and Adolescents, Pediatrics 2018;142:320182161

40. There are no scientifically validated gender incongruence training programs at universities in the United States. Under the guise of compassion for the bullied, endocrinologists are promoting chemical treatment that forever creates medical suffering, introducing complications such as sterility, increased stroke and cancer risk all to supposedly save the gender-incongruent person from taking his/her life to end the suffering imposed upon them by society. The suicide risk is hyper-inflated to as high as 50% when in reality it is actually 5%, as reported by the Williams Institute.[32] The mantra of "insistent, persistent and consistent" as a means to diagnose the entity of gender incongruence is not scientifically supported. The Nuremburg Guidelines are an established framework that have been overlooked by WPATH, the Endocrine Society, the Pediatric Endocrine Society and the American Academy of Pediatrics.

41. The requirement that society at large, and school systems in particular, should grant special regulatory privileges to a gender-incongruent person which is intended to further a student's belief that they are born into the body of the wrong sex is an endorsement of a form of medical "treatment" which has no scientific basis. Allowing a biologic female to use a male-designated bathroom facility is one of several "gender affirming" care options, but it is creating harm to at least two parties. The harm to the gender incongruent person is that it promotes a pathway to inevitable long-term medical and psychological morbidity. The premise of gender affirming care can be managed through other methods without requiring school systems to permit transgender students to use the restroom associated with their new gender identity. The second party harmed is the student without gender incongruence who must suffer emotionally while being told they must tolerate the presence of an opposite sex individual in a sexually segregated space and embrace the regulation which gives the gender incongruent person special privileges as if they were based on a civil right founded on immutable biology.

Quentin L. Van Meter, M.D.
Pediatric Endocrinologist

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32. Wilson BDM et al, Characteristics and Mental Health of Gender Nonconforming Adolescents in California, Health Policy Fact Sheet, The Williams Institute UCLA School of Law December 2017

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Medical School:	Medical College of Virginia, 1973 M.D. – 1973

CLINICAL TRAINING:

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Hospital:	Naval Regional Medical Center, Oakland
Position:	Pediatric Intern – 1973 – 1974 Pediatric Resident – 1974 – 1976
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Position:	Fellow, Pediatric Endocrinology 1978 – 1980 Fellowship Program Director: Claude Migeon, M.D.
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	Chairman, Georgia Chapter Legislative Committee, 1996 – 2006
Fellow:	The American College of Pediatricians, 2007 – present Member of the Board of Directors, 2008- present Vice President/President, 2015-present
Member:	Pediatric Endocrine Society, 1989 – present
Member:	American Diabetes Association Professional Section, 1988 – present
Member:	Endocrine Society, 1994-present
Member:	Southern Pediatric Endocrine Society, 1992 – Present
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Institution:	Emory University School of Medicine
Position:	Associate Clinical Professor, Pediatrics, 1991 – present
Institution:	University of California, San Francisco
Position:	Associate Clinical Professor, Pediatrics, 1989 – 1991
Institution:	University of California, San Diego, School of Medicine
Position:	Assistant Clinical Professor, Pediatrics, 1980 – 1986
Institution:	LSU School of Medicine, Clinical Instructor, Pediatrics, 1977 – 1978

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	Staff Pediatrician, Naval Regional Medical Center, Oakland, 1976

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New Orleans, 1976 – 1978

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1980 – 1986

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OTHER PROFESSIONAL ACTIVITIES:

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1991 – 1994

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September 1991 – October 2003

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Speaker's Bureau
Novo Nordisk, Pfizer, Endo, Abbvie
AAP Eqipp course on Growth- development committee- 2012

PUBLICATIONS: (Articles in Peer Reviewed Journals)

Riddick, JR, Flora R., Van Meter, QL:
"Computerized Preparation of Two-Way Analysis of Variance Control Charts for Clinical Chemistry," Clinical Chemistry, 18:250, March 1972.

Van Meter, QL, Gareis FJ, Hayes, JW, Wilson, CB:
"Galactorrhea in a 12 Year Old Boy with Chromophobe Adenoma," J. Pediatrics 90:756, May 1977.

Plotnick, LP, Van Meter, QL, Kowarski, AA, "Human Growth Hormone Treatment of Children with Growth Failure and Normal Growth Hormone Levels by Immunoassay: Lack of Correlation with Somatomedin Generation: Pediatrics 71:324, March 1983.

Brawley, RW, Van Meter, QL, "Mebendazole Ascaris Migration," W.J. Med, 145:514015, October 1986.

Van Meter, QL, "The Role of the Primary Care Physician in Caring for Patients with Type-1 Diabetes," Comp Ther 1998; 24(2):93–101

Midyett LK, Rogol AD, Van Meter QL, Frane J, and Bright GM, "Recombinant Insulin-Like Growth factor (IGF)-I Treatment in Short Children with Low IGF-I Levels: First-Year Results from a Randomized Clinical Trial," J Clin Endocrinol Metab, 2010;95:611–619.

ABSTRACTS:

Van Meter,Q L, & Lee, PA: "Evaluation of Puberty in Male and Female Patients with Noonan Syndrome," Pediatric Research 14:485, 1980.

Van Meter, QL, et al: "Characterization of Pituitary Function in Double Bolus GnRH Infusion as a Diagnostic Tool," Pediatric Research 32:111, 1984.

Van Meter, QL, Felix, SD, Lin, FL: "Evaluation of the Pituitary-Adrenal Axis in Patients Treated with nasal Beclomethasone," (Presented at the 1991 Annual Meeting of the Endocrine Society and the 6th Annual Naval Academic Research Competition, Bethesda, MD, 17 May, 1991).

Rogol AD Midyett LK Van Meter Q, Frane J, Baily J, and Bright GM, Recombinant Human IGF-1 for Children with Primary IGF-1 Deficiency (IGFD): Safety Data from Ongoing Clinical Trials (presented at the PAS 2007, Toronto).

Van Meter Q, Midyett LK, Deeb L et al, Prevalence of primary IGFD among untreated children with short stature in a prospective, multicenter study (Poster POO715) ICE Rio de Janeiro, Brazil 2008.

G.M. Bright[1], W.V.Moore[2], J.Nguyen[3], G. Kletter[4], B. S. Miller[5], Q. L. Van Meter[6], E. Humphriss[1], J.A. Moore[7] and J.L. Cleland[1] Results of a Phase 1b Study of a new long-acting human growth hormone (VRS-317) in pediatric growth hormone deficiency (PGHD). PAS 2014 May 2014

Van Meter Q, Welstead B and Low J, Characteristics of a Population of Obese Children and Adolescents: Suggesting a New Paradigm, presented at ESPE meeting, Dublin 2014.

Wayne V. Moore[1], Patricia Y. Fechner[2], Huong Jil Nguyen[3], Quentin L. Van Meter[4], John S. Fuqua[5] , Bradley S. Miller[6], David Ng[7], Eric Humphriss[8], R. W. Charlton[8], George M. Bright[8], Safety and Efficacy of Somavaratan (VRS-317), a Long-Acting rhGH, in Children with Growth Hormone Deficiency (GHD): 3-Year Update of the VERTICAL & VISTA Trials, presented at the 2017 Endocrine Society meeting in Orlando FL

Bradley S. Miller[1], Wayne V. Moore[2], Patricia Y. Fechner[3], Huong Jil Nguyen[4], Quentin L. Van Meter[5], John S. Fuqua[6], David Ng[7], Eric Humphriss[8], R. W. Charlton[8], George M. Bright[8], 3-Year Update of the Phase 2a and Long-term Safety Studies (VERTICAL and VISTA) of Somavaratan (VRS-317), a Long-acting rhGH for the Treatment of Pediatric Growth Hormone Deficiency, presented at the 2017 IMPE meeting in Washington D.C.

Laidlaw MK, Van Meter QL, Hruz PW, Von Mol A, and Malone WJ, Letter to the Editor: "Endocrine Treatment of Gender-Dysphoric/Gender-Incongruent Persons: An Endocrine Society Clinical Practice Guideline," J CLin Endo Metab 2019;104: 1-2.

ADDITIONAL PRESENTATIONS/LECTURES:

Pediatrics Update, CME Associates, San Diego – Orlando Annual Conferences: Lectures on Pediatric Endocrine Subjects – 1986 – 2001. Course Moderator, 1997, 1998, 1999, 2000, 2001

Endocrine and Gastroenterology Update, CME Associates, Maui HI Nov 2001, Lecturer and Course Moderator

Lecture on Panhypopitutarism, Pharmacia Conference, Nashville TN April 2002.

Family Medicine Review Course, Orlando, FL, 1992 – 2001

Pediatric Grand Rounds, Tanner Medical Center, October 1997

Pediatric Grand Rounds, Hughes Spaulding Children's Hospital, September, 2003

Pediatrics in the Park, Fall CME meeting for the Georgia Chapter of the American Academy of Pediatrics, November 2003

Pediatric Grand Rounds, Columbus Regional Medical Center, January 2004

Frontiers in Pediatrics CME Course, sponsored by the Atlanta Children's Health Network, Atlanta, March 2004.

Pediatric Grand Rounds, Eggleston Children's Hospital, May 2004.

Sue Schley Matthews Pediatric Conference, Columbus Regional Medical Center, September 2004

56th Annual Scientific Assembly and Exhibition of the Georgia Academy of Family Physicians, Nov 2004

Program Co-Chairman: Southern Pediatric Endocrine Society Annual meeting, Nov 2004, November 2014

Presentations on Diabetes, Growth Failure, and Thyroid Disease to the Postgraduate Pediatric Nurse Practitioner Program, Georgia State University, Nov 2005, June 2006, May 2007

Issues in Medicine, US Medical Congress Conference and Exhibition, Las Vegas, meeting planner and speaker, June, 2006

CME Presentations for the Georgia Chapter of the American Academy of Pediatrics Spring and Fall Meetings 2004-present

Pediatric Grand Rounds, Columbus Regional Medical Center, Columbus, GA, 2011-present

Human Growth Foundation Regional CME Conference, Atlanta GA March 2013, February 2014 Columbus Georgia

International Federation of Therapeutic Counseling Choice: Transgender Medicine, IFTCC Launch, October 15, 2018 London, Third International Congress, October 25 2018 Budapest.

Audio Digest Pediatrics - ① v. 41, no. 4; ② v. 41, no. 20; ③ v. 43, no. 17

Audio Digest Family Practice - ① v. 42, no. 5; ② v. 44, no. 11; ③ v. 44, no. 44; ④ v. 45, no 15

Audio Digest Otolaryngology - ① v. 32, no. 14

CURRENT HOSPITAL APPOINTMENTS:

Eggleston/Scottish Rite Children's Hospitals, active staff, Pediatric Endocrinology

PAST AND CURRENT CLINICAL RESEARCH:

2006	Sanofi-Aventis HMR1964D/3001	study completed 2007
2006	Tercica MS301-	study completed 2008
2007	Tercica MS310-	study completed 2008
2007	Tercica MS306-	study completed 2010
2007	Tercica MS316-	study completed 2012
2008	EMD Serono 28358	study completed 2009
2012	Versartis 12VR2	study completed 2014
2012	Debiopharm 8206-CPP-301	study started July 2012
2013	Versartis 13 VR3	study started Dec 2013
2014	Novo-Nordisk Elipse	study started 2014
2015	Versartis 14 VR4	study completed 2017
2017	Mannkind MKC-TI-155	study started 2017

LEGAL EXPERT WITNESS:

2017 North Carolina Legislature- transgender bathroom bill
2018 Jessica Siefert transgender case, Cincinnati, OH
2018 Alberta, Canada school system transgender case
2018 Decatur GA School Board transgender case

Customary charges for medical legal review, deposition and court testimony for
Quentin L. Van Meter, M.D.

Retainer- $1500

Record review- $350/h

Deposition and Testimony- $450/h

If testimony requires travel, lodging, and meals- reimbursement for full receipted cost

If testimony requires days away from the medical practice, flat fee of $3500 per day involved.